

Figure SC850.F18. ES-933, "Request for Information Regarding Claims Filed Under the Federal Employees' Compensation Act"

(STATE AGENCY NAME) REQUEST FOR INFORMATION REGARDING CLAIMS FILED UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT			
LOCAL OFFICE:	DATE OF REQUEST:	DATE CLAIM FILED:	DATE A/C FILED:
<b>SECTION I. IDENTIFICATION DATA</b>			
NAME (LAST, FIRST, MIDDLE, MAIDEN (IF ANY))		FEDERAL EMPLOYING AGENCY (INCLUDE COMPLETE ADDRESS)	
SOCIAL SECURITY NUMBER ____/____/____		PLACE OF EMPLOYMENT (CITY, STATE OR COUNTRY)	
BIRTH DATE (MM/DD/YY)		POSITION TITLE	
<b>SECTION II. FEDERAL AGENCY REPLY</b>			
INSTRUCTIONS: FEDERAL AGENCY TO COMPLETE AT LEAST ITEM 1 OF SECTION II AND RETURN COPY TO STATE AGENCY AS SOON AS POSSIBLE; EXTENSIVE DELAY MAY CAUSE UNNECESSARY POSTPONEMENT OF UNEMPLOYMENT BENEFITS OR RESULT IN OVERPAYMENT OF SUCH BENEFITS.			
1. HAS THE ABOVE EMPLOYEE FILED A CLAIM FOR FEDERAL EMPLOYEES' COMPENSATION? ____ YES ____ NO			
2. IF CLAIM FILED, A. DATE CLAIM FILED (MM/DD/YY) ____/____/____      B. CLAIM IS/WAS: ____ APPROVED ____ REJECTED ____ PENDING			
NOTE: IF CLAIM IS "PENDING," PLEASE RETURN ONE COPY OF THIS FORM TO THE STATE AGENCY (ADDRESS ON REVERSE) COMPLETED THROUGH ABOVE ITEM. SUBSEQUENTLY, WHEN A DECISION HAS BEEN MADE, PLEASE FURNISH (ON SECOND COPY OF THIS FORM) APPROPRIATE, COMPLETE INFORMATION AND SEND IT TO THE STATE AGENCY.			
3. IF CLAIM WAS APPROVED A. RATE OF COMPENSATION \$ ____      B. RATE IN ITEM 3.A. IS FOR: ____ 1 WEEK ____ 2 WEEKS ____ 1 MONTH      C. DATE COMPENSATION BEGAN (MM/DD/YY) ____/____/____      D. ENDING DATE (IF KNOWN) (MM/DD/YY) ____/____/____			
4. DESCRIBE THE DISABILITY FOR WHICH COMPENSATION WAS CLAIMED OR APPROVED IN TERMS OF NATURE, DEGREE, AND EXPECTED DURATION:			
5. LIST COMPENSATION PAID FOR THE PAST PERIODS WITH RESPECT TO WEEK-ENDING DATES SHOWN BELOW. (IF NONE SHOWN, INFORMATION IS NOT NEEDED BY THE STATE AGENCY.)			
WEEK ENDING ____	AMOUNT \$ ____	WEEK ENDING ____	AMOUNT \$ ____
WEEK ENDING ____	AMOUNT \$ ____	WEEK ENDING ____	AMOUNT \$ ____
REMARKS:			
<b>SECTION III. CERTIFICATION</b>			
I CERTIFY THAT I HAVE EXAMINED THIS REQUEST AND THAT THE ABOVE INFORMATION WAS OBTAINED FROM OFFICIAL RECORDS OF THE FEDERAL AGENCY (USE ADDRESS ON REVERSE)			
SIGNATURE OF OFFICIAL	TITLE	DATE	PHONE
NAME OF THIS FEDERAL AGENCY (IF DIFFERENT THAN SHOWN IN SECTION I)		ADDRESS OF THIS OFFICE (IF DIFFERENT FROM THAT SHOWN ON REVERSE)	

VII-7

APRIL 1994

TO BE COMPLETED BY THE DEPARTMENT OF LABOR, OWCP